Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Carrier's Austin Representative Box
Box # 29

MFDR Date Received
NOVEMBER 19, 2003

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M5-05-2828-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated December 12, 2003: "The Carrier denied payment with payment exception code 'V' for all billed charges provided in the UB-92. Contrary to the Carrier's varying positions as to denial of payment, the Carrier provided preauthorization for the services rendered on November 20, 2002."

Requestor's Supplemental Position Summary Dated November 10, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment… The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons."

Amount in Dispute: $157,853.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 3, 2003: "Harris & Harris represents the City of Houston in this matter."

Response Submitted by: Harris & Harris

Respondent's Supplemental Position Summary Dated January 2, 2004: "As a review of the attached EOBs/TWCC-62s indicates, the Carrier denied the services made the basis of this matter per code 'V' due to a lack of medical necessity. This lack of necessity was predicated upon a peer review. The Carrier respectfully requests this matter be referred to the appropriate Independent Review Organization as contemplated by the Act and the relevant Commission rules for a determination of the medical necessity of the treatments at issue in this case."

Responses Submitted by: Harris & Harris

Respondent's Supplemental Position Summary Dated September 8, 2011: "Vista Medical Center has failed to demonstrate that the dates of service meet the minimum requirements set out under TDI-DWC Rule 134.401(c)(6) for exceeding the minimum stop-loss threshold of $40,000 and that the admission involved unusually costly and unusually extensive services…Carrier attaches as evidence Exhibit 3, the Affidavit of Dr.

James Hood with excerpts of the Hospital's records submitted for this admission indicating his expert opinion that this admission does not involve unusually extensive services beyond what would be expected for such care. In additional to any positions previously stated, the City also asserts that the admission fails the second prong of the Stop Loss test and should be awarded based on the per diem methodology, if at all."

Responses Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
December 4, 2002 through December 16, 2002	Inpatient Hospital Services	$157,853.85	$35.579.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305, §133.307, 133.308, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving fee and medical necessity disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.600, 26 *Texas Register* 9874, effective January 1, 2002, requires preauthorization for inpatient hospital services.
4. 28 Texas Administrative Code §133.301, 25 *Texas Register* 2115, effective July 15, 2000, addresses retrospective review of medical bills.
5. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - V-Unnecessary treatment (with peer review).

Issues

1. Did the workers' compensation insurance carrier have the authority to retrospectively review the services in dispute?
2. Does a medical necessity issue exist in this case?
3. Did the audited charges exceed $40,000.00?
4. Did the admission in dispute involve unusually extensive services?
5. Did the admission in dispute involve unusually costly services?
6. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this dispute supplemented the original MDR submissions. The division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate.

Documentation filed by the requestor and respondent to date is considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold…" In that same opinion, the Third Court of Appeals states that the stop loss exception "…was meant to apply on a case-by-case basis in relatively few cases." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The respondent denied payment for the twelve day inpatient hospital stay, due to reason code "V-Unnecessary treatment (with peer review)."

   The requestor contends that payment is due based upon "Contrary to the Carrier's varying positions as to denial of payment, the Carrier provided preauthorization for the services rendered on November 20, 2002." In support of their position, the requestor submitted copies of preauthorization reports from the respondent's preauthorization agent, Spectrum Managed Care. These reports support requestor's position that preauthorization was approved for the following:

   - November 20, 2002, preauthorization approval for a "2-day inpatient stay".
   - December 9, 2002, preauthorization approval for a "3 additional inpatient stay days – to continue IV fluids"

   Therefore, the Division finds that the respondent preauthorized a five-day inpatient hospital stay.

   28 Texas Administrative Code §133.301(a) states, in pertinent part, that "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." Therefore, the respondent did not have the authority to retrospectively review the medical necessity of the preauthorized five days; however, the seven days that were not preauthorized the denial code "V" is supported.

2. Since the hospitalization was denied based upon medical necessity, the case was forwarded to an Independent Review Organization (IRO) for review of the medical necessity issue per 28 Texas Administrative Code §133.308 on August 17, 2005.

   On August 25, 2005, the Division pursuant to the provisions of 28 Texas Administrative Code §133.308, ordered the requestor to remit payment in the amount of $650.00 to the IRO within 10 days of receipt of the Order. The Order clearly indicated that noncompliance with the Order would result in immediate dismissal of the medical necessity dispute. The requestor did not comply with the Order.

   Pursuant to 28 Texas Administrative Code §133.308(r)(7)(8) and (11), due to non-compliance with the Division order, the Division dismissed the medical necessity dispute. Therefore, a medical necessity issue does not exist in this dispute. The only dates of service available for review are the preauthorized dates of December 4, 2002 through December 9, 2002.

3. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, 28 Texas Administrative Code §134.401(c)(6)(A)(v) states that "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the respondent finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $210,471.80. The Division concludes that the total audited charges exceed $40,000.00.

4. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services" and further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." In its position, the requestor states:

   > The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when

compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ('LOS') for workers' compensation inpatient admission is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

5. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for similar spinal surgery services or admissions. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar spinal surgery services or admissions.

6. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was twelve days; however, documentation supports that the Carrier pre-authorized a length of stay of five days in

accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $5,590.00 for the five authorized days.

- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278); and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that 46 items were billed under revenue code 0278. These items are eligible for separate payment under §134.401(c)(4)(A) as follows:

Itemized Statement Description	Units	Cost per Unit	Cost + 10%
Rod Template, 15cm	2	$115.00	$253.00
Spinal Fusion Stimulator	1	$4,465.00	$4,911.50
Allograft Tis Putty	4	$1,150.00	$5,060.00
BAK Interbody Cage	2	$2,720.00	$5,984.00
Implant Assembly	3	$245.00	$808.50
Trans Con Nut	8	$65.00	$572.00
Trans Con Insert	8	$95.00	$836.00
Transverse Connector	3	$185.00	$610.50
Transverse Connector	1	$310.00	$341.00
End Cap	2	$159.00	$349.80
Silhouet Rod 5.5X20	2	$290.00	$638.00
Poly Screw	10	$875.00	$9,625.00
		TOTAL	$29,989.30

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $315.67 for revenue code 382-Blood-Whole Blood. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 382 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $289.00/unit for Dilaudid PCA 100ml. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $35,579.30. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in $35,579.30 additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $35,579.30 plus applicable accrued interest per 28 Texas Administrative Code §134.803 , due within 30 days of receipt of this Order.

Authorized Signature

		01/30/2014
Signature	Medical Fee Dispute Resolution Officer	Date
		01/30/2014
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

favor de llamar a 512-804-4812.